DENTAL INSURANCE ENROLLMENT FORM

CITY OF MILWAUKEE

Department of Employee Relations/Employee Benefits Division

(All Plans)

A	DENTAL PLAN NAME	CLINIC/OFFICE DESIRED	DENTAL CENTER / LOCATION #	CONTRACT DESIRED
				☐ SINGLE ☐ FAMILY

B	YOUR LAST NAME	FIRST NAME	INIT.	GENDER	DATE OF BIRTH	SOCIAL SECURITY NUMBER

HOME ADDRESS	APT. NUMBER	CITY	STATE	ZIP CODE

TELEPHONE NUMBER	EMPLOYEE ID	MARITAL STATUS
		☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW/WIDOWER

CITY START DATE	RETURN TO WORK DATE	JOB TITLE	DEPARTMENT/BUREAU

C FAMILY COVERAGE ---- LIST ALL PERSONS TO BE INCLUDED

	LAST NAME	FIRST NAME	INIT	SEX	DATE OF BIRTH	SOCIAL SECURITY NUMBER	RELATIONSHIP	DENTAL OFFICE AND NO. (If different from above)
	SPOUSE			M ☐ F ☐				
	DOMESTIC PARTNER			M ☐ F ☐				
DEPENDENT CHILDREN				M ☐ F ☐				
				M ☐ F ☐				
				M ☐ F ☐				
				M ☐ F ☐				
				M ☐ F ☐				

D REASON FOR SUBMITTING ENROLLMENT FORM:

☐ INITIAL ENROLLMENT ☐ ADD DEPENDENT ☐ DELETE DEPENDENT Name _____ DATE / /

☐ OPEN ENROLLMENT ☐ SINGLE TO FAMILY ☐ MARRIAGE Maiden Name _____ DATE / /

☐ RETURN TO WORK ☐ FAMILY TO SINGLE ☐ DIVORCE DATE / / ☐ DEATH DATE / /

☐ DENTAL CLINIC CHANGE ☐ OTHER _____

E IS ANYONE NAMED ON THIS ENROLLMENT FORM COVERED BY ANOTHER GROUP DENTAL INSURANCE PLAN? ☐ YES ☐ NO

NAME OF POLICYHOLDER (Usually your Spouse) _____ POLICYHOLDER'S EMPLOYER _____

IF YES, NAME OF INSURANCE COMPANY _____ POLICYHOLDER'S IDENTIFICATION NUMBER _____

X _____ / /

YOUR SIGNATURE _____ DATE SIGNED _____

FOR OFFICE USE ONLY

GROUP NUMBER	SECTION NUMBER	PENSION NUMBER / EMPLOYEE ID #	UNION REP.
EFFECTIVE DATE	**P.C.**	**DIVISION / LOCATION**	

Make Original and two copies of application: Original for Dental Plan; One for EBD; One for your copy

03/06

TERMS AND CONDITIONS

1. To the best of my knowledge, all statements and answers on this enrollment form are complete and true.

2. I agree to pay in advance the current premium for this dental insurance plan and I authorize the City of Milwaukee to deduct from my wages, salary, or pension an amount sufficient to provide for regular premium payments that are not otherwise contributed by the City.

3. I agree that any physician, dentist, hospital, or other health or dental care provider who attends or has attended me, my spouse, or any of my dependents covered by the dental insurance plan, is authorized to furnish the plan, during a period extending to six months following the termination of my enrollment in the plan, with any information from patient dental or health care records for any purpose related to the plan.

4. Any children listed on this enrollment form must be unmarried and dependent on me, my spouse, or my former spouse for support and maintenance (as measured by standards employed by the IRS for determining dependency), or be a full-time student in an accredited academic, professional or registered trade school. If over the age of 25, they must be disabled so as to be incapable of self-support.

NOTICE TO EMPLOYEES AND RETIREES REGARDING THIRTY DAY RULE

Active employees and retired employees are responsible for keeping their enrollment status current – notifying the Employee Benefits Division within 30 days of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents who become dependents again, and deaths. New employees must complete health and dental enrollment forms within 30 days of their City start date and employees returning to work must also complete health and dental enrollment forms within 30 days of their return-to-work date. (By not complying with the Thirty Day Rule, you may expose the City and/or yourself to additional costs.) There are no exceptions to this rule.